Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Caspofungin	
and Proven or probable invasive fungal infection, to Possible invasive fungal infection and	piologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or ol or guideline that has been endorsed by the Health NZ Hospital. Ito be prescribed under an established protocol Infectious disease physician or a clinical microbiologist) considers the treatment to be

I confirm that the above details are correct:	
Signed:	Date: